Patient Eligibility Screening Record
Vaccines for Children Program

1. Initial Screening Date: (_ _ / _ _ / _ _ _ _)
   M M D D Y Y Y Y

2. Child's Name: _____ __
   Last Name First MI

3. Child's Date of Birth: (_ _ / _ _ / _ _ _ _)
   M M D D Y Y Y Y

4. Parent/Guardian/Individual of Record: _____ __
   Last Name First MI

5. Is your facility a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)?

   ☐ Yes ☐ No

6. Primary Provider's Name: _____ _____ __
   Last Name First MI

7. Does this patient qualifies for immunization through the VFC program because he/she (check only one box):
   a) Yes, is enrolled in Medicaid □
   b) Yes, does not have health insurance □
   c) Yes, is an American Indian or Alaska Native □
   d) Yes, is underinsured (has health insurance that does not pay for vaccinations)* □
   f) No, this child does not qualify for immunizations through the VFC program because he/she does not met the eligibility criteria. □

Eligibility Changes					
Date	Is enrolled in Medicaid	Does not have health insurance	Is an American Indian or Alaska Native	Is underinsured (has health insurance that does not pay for vaccinations)*	Does not meet eligibility criteria

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office. The record may be completed by the parent, guardian, or individual of record or by the health care provider. VFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed. This same record will satisfy the requirements for all subsequent vaccinations, as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

*** To be supported with VFC purchased vaccine, underinsured children must be vaccinated through a FQHC or RHC.**

Comprehensive Certification Form for American Indians and Alaska Natives

This form may be substituted for individual VFC screening records when 100% of the persons to be immunized at this facility are American Indians or Alaska Natives.

Provider enrollment and Provider Profile forms for this practice must be on file with the State Health Department or public health agency of record. Certification must be re-issued annually when provider profile is submitted.

Date: _____

Facility Name: _____

Address: _____
(Street)

_____ _____ _____
City **State** **Zip Code**

Telephone: ( ) _____ **Fax: ( )** _____

E-mail: _____

Authorizing Official: _____ _____
(Please Print the Authorizing Officials Name) (Signature of Authorizing Official)

Retain a copy of this form at your facility and send the original to the State Health Department or state public health agency of record.

Comprehensive Certification Form for Children Who Are Enrolled in Medicaid

This form may be substituted for individual VFC screening records when 100% of the persons to be immunized at this facility are Medicaid enrolled.

Provider enrollment and Provider Profile forms for this practice must be on file with the State Health Department or public health agency of record. Certification must be re-issued annually when provider profile is submitted.

Date: _____

Facility Name: _____

Address: _____
(Street)

_____ _____ _____
City **State** **Zip Code**

Telephone:( ) _____ **Fax:**( ) _____

E-mail: _____

Authorizing Official: _____ _____
(Please Print the Authorizing Officials Name) (Signature of Authorizing Official)

Retain a copy of this form at your facility and send the original to the State Health Department or state public health agency of record.

Patient Eligibility Screening Record
Vaccines for Children Program in Family Planning Clinics

1. Initial Screening Date: __ __ __ __ __ __ __ __
   M M D D Y Y Y Y

2. Child's Name: _____ __
   Last Name First MI

3. Child's Date of Birth: __ __ __ __ __ __ __ __
   M M D D Y Y Y Y

4. Parent/Guardian/Individual of Record: _____ __
   Last Name First MI

5. Is your facility a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)?

   ☐ Yes ☐ No

6. Primary Provider's Name: _____ _____ __
   Last Name First MI

7. Does this patient qualifies for immunization through the VFC program because he/she (check only one box):
   a) Yes, is enrolled in Medicaid □
   b) Yes, does not have health insurance □
   c) Yes, is an American Indian or Alaska Native □
   d) Yes, is underinsured (has health insurance that does not pay for vaccinations)* □
   e) Yes, is an unaccompanied minor without insurance information □
   f) No, this child does not qualify for immunizations through the VFC program because he/she does not met the eligibility criteria □

Eligibility Changes						
Date	Is enrolled in Medicaid	Does not have health insurance	Is an American Indian or Alaska Native	Is underinsured (has health insurance that does not pay for vaccinations)*	Is an unaccompanied minor without insurance information	Does not meet eligibility criteria

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office. The record may be completed by the parent, guardian, individual of record or by the health care provider. VFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed. This same record will satisfy the requirements for all subsequent vaccinations, as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

* To be supported with VFC purchased vaccine, underinsured children must be vaccinated through a FQHC or RHC.

Family Planning Clinic
Unaccompanied Minor without Insurance Information VFC Vaccine Log

Directions: This form must be completed and submitted to the state immunization program on a monthly basis. To prevent duplication of patient count, please record all vaccines administered to one patient on a single line. This report is in addition to other VFC reports required by the state immunization program. In completing this log, document only the administration of any VFC vaccine to unaccompanied minors (through 18 years of age) who present without insurance information. Please keep one copy for your clinic's records and send one to the State Immunization Program at the address below:

State Immunization Program
Mailing Address
City, State ZIP Code
Attention:_____

Clinic name: _____

Person completing this log: _____

Phone number of person completing this log:_____

Log for: Month_____ Year_____

Patient	Date VFC vaccine was administered	List names of VFC vaccines administered	Total number of VFC vaccines administered to this patient
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
Total number of VFC vaccines, by type, administered this month:			

Sample
Border State Memorandum of Understanding – VFC

This agreement has been designed and ratified by the [**State A**] Department of Health and the [**State B**] Department of Health, hereafter referred to as **State A and State B**.

It is the purpose of this agreement to provide vaccines from the Vaccines for Children (VFC) program to Medicaid-enrolled and other children who are eligible for VFC vaccinations, who reside in one state but are served by private health care providers in a neighboring state.

Whereas high immunization rates are in the interest of both states and ease of access to immunizations is a key factor in maintaining high immunization rates, it is mutually agreed that ***State A*** will provide VFC program vaccine to enrolled health care providers with practices located in ***State A*** so that VFC-eligible children will have access to the vaccine, regardless of their state of residence. Likewise, it is mutually agreed that ***State B*** will provide VFC program vaccine to enrolled health care providers with practices located in ***State B*** so that VFC-eligible children will have access to the vaccine, regardless of their state of residence. *Note: It is not necessary that **State A** provide vaccine to providers in **State B** or vise-versa. The deciding factor is the practice site of the provider, not the residence of the child.*

Sources of Funds (Vaccines)
The federal VFC program shall be the source of vaccines necessary to implement this agreement. No other funding is deemed necessary for the implementation of this agreement. Each of the parties to this agreement are financially obligated for any costs incurred within their state as a result of the execution of this agreement.

Contract Management
The work described herein shall be performed under the coordination of the Program Managers of the **State A and State B** Immunization Programs, or their designees, who will provide assistance and guidance to the other party, as may be necessary for the performance of this agreement.

Amendments
The parties to this agreement must mutually agree upon all changes to this agreement in writing.

Indemnification
Each party shall defend, protect and hold harmless the other party from and against all claims, suits, and/or actions arising from any negligent or intentional act or omission of that party's employees, agents, and/or authorized subcontractor(s) while performing this contract, but does not extend to allegations of fraud, misuse of public funds or property, and defiance of federal laws, policies or statutes.

Reporting Requirements
Both parties to this agreement shall comply with all existing and subsequently levied federal VFC reporting requirements.

Savings
In the event of termination, reduction, or limitation of the Vaccines for Children program after the effective date of this agreement, either party may terminate the agreement under the "termination" clause cited below, and subject to renegotiation of new funding limitations and conditions.

Termination
Except as otherwise provided in this document, either party may terminate this agreement by submitting written notification of their intent to terminate 30 days prior to the actual dissolution. If this agreement is so terminated, the terminating party shall be liable only for performance rendered prior to the effective date of termination, and only to the extent outlined in the agreement.

In witness thereof, the signatures of these parties affirm their intent to execute this agreement.

_____ _____

Signature of Contract Manager
Date
State A Department of Health

_____ _____

Signature of Contract Manager
Date
State B Department of Health